A survey of IPV perpetrator treatment providers:

Ready for evidence-based practice?

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Abstract

A debate persists regarding the effectiveness of batterer intervention programs, the predominant form of intervention for individuals who have perpetrated intimate partner violence (IPV). Social science research has identified some promising research trends – e.g., the effectiveness of Motivational Interviewing and process factors that maintain an effective therapist-client alliance, what clients say facilitators can do to keep them engaged and motivated, and, for certain low-risk populations, the viability of couples counseling. Unfortunately, most front-line treatment providers lack access to much of this research, which appears primarily in peer-reviewed journals. A previous national survey of BIPs reported that, on the whole, BIP group facilitators have ample clinical experience, but are poorly informed about IPV risk factors and dynamics; and while they report substantial training, the nature of that training, and the extent to which the training accurately reflects current research, remains unknown. BIPs, and most treatment providers, including licensed mental health professionals, depend on organizations who too often lack reliable, up-to-date information about domestic violence. The Association of Domestic Violence Intervention Providers (ADVIP) was created by the first author to provide a platform where researchers and providers could cooperate by exchanging information and resources. This article reports on findings from a larger follow-up to the 2016 survey, that sought to elicit views on how to increase cooperation between domestic violence scholars and treatment providers and advance evidence-based practice (EBP), and to gauge the role of ADVIP in this effort.

Keywords: intimate partner violence, perpetrator programs, batterer intervention, evidence-based practice

Each year, approximately 7 million women and 7 million men are physically assaulted by an intimate partner, and the number of individuals who experience emotional abuse is much higher (Black et al., 2011; Carney & Barner, 2012). Interventions in intimate partner violence (IPV) are conducted in a variety of sectors and modalities, for voluntary clients and those who have been mandated by a criminal court. Because nearly all of the states discourage or prohibit couples or family therapy (Babcock et al., 2016), adjudicated individuals are typically required to participate in (usually same-sex) counseling groups known as *batterer intervention programs*, or BIPs, with the victims separately referred to victim support services, often at a local shelter. Less is known about the treatment of voluntary clients, who may initially present with other issues (Stith, McCollum, & Rosen, 2011).

BIP Outcomes

The first wave of BIP outcome studies generated mixed results. Some, based in quasi-experimental designs, reported moderate effects for BIPs (e.g., Gondolf, 2011; 2012); others, using randomized control trial (RCT) research, found traditional psychoeducational group formats to be minimally effective in preventing further acts of violence against victims, perhaps only 5% above client monitoring from the courts (Babcock, Green, & Robie, 2004; Babcock et al., 2016). Not surprisingly, IPV recidivism rates are high; in California, for example, which has among the nation's toughest domestic violence policies, only half of offenders mandated to batterer intervention will actually complete their sessions as required by law (California State Auditor, 2006). The relative failure of batterer intervention, relative to general counseling and psychotherapy, may partly be attributed to the involuntary status of its participants; still, treatment effects are significantly higher for acting-out adolescents, substance abusers, and general criminal offenders (Babcock et al., 2004). Inherently limiting may be the uniform, "one-

size-fits-all" statutes regulating these programs, which stipulate a set number of weeks (26 is the average) for all offenders. Currently, only Colorado (Gover, 2011; Richards, Gover, Tomsich, Hansen, & Davis, 2017) assigns treatment modality, intensity and length based on a risk assessment and Risk-Need-Responsivity (RNR) principles. Although group work has its advantages (e.g., Hamel, in press), there are limitations to a modality that treats only one family member, and is therefore less responsive to the issues and problems that can be elucidated from a systemic, multi-modal perspective (Hamel & Nicholls, 2007; Hamel, 2014).

A fundamental drawback to BIPs is that the state standards governing them do not adequately reflect empirical research and best practice guidelines (Babcock et al., 2016; Maiuro & Eberle, 2008). Largely informed by the experiences of battered women advocates and other special interests who view IPV within the gendered lenses of feminist theory, treatment emphasis has been on male perpetration, control as the default motive, a rigid perpetrator/victim dichotomy, and dismissal of important risk factors such as unemployment, adverse childhood experience, emotional dysregulation, substance abuse, personality disorder, and relationship conflict dynamics (Dutton & Corvo, 2006; Hamel, 2019; Nicholls & Hamel, 2013; Stuart, 2005). Aside from their ideological underpinnings, state standards for certification and training of group facilitators would appear inadequate in many important ways. In many states, for instance, one may be certified to conduct groups without any mental health background whatsoever, and there is little if any requirement that facilitators maintain continuing education in the latest research findings most relevant to assessment and treatment (Babcock et al, 2016; Maiuro & Eberle, 2008). Evidence-based practice (EBP), it would seem, has not been a priority in the field of batterer intervention – at least not among policy-makers.

The American Psychological Association (APA Presidential Task Force, 2006) defines EBP as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (p. 273). Drawing from this definition and psychotherapy outcome studies highlighting the importance of common factors (e.g. working therapist alliance, empathy, positive regard, goal consensus, genuineness; Wampold & Imel, 2015), BIP research has focused away from comparing treatment models to examining trans-theoretical factors such as motivation and the role of group facilitators in maintaining a strong alliance with group participants (Eckhardt, Murphy, Black, & Suhr, 2006; Eckhardt, Murphy, Whitaker, Sprunger, Dykstra, & Woodard, 2013). Interventions using Motivational Interviewing (MI) predict greater treatment compliance and reduced rates of recidivism, along with trauma-informed treatment and models that incorporate mindfulness meditation and other aspects of Acceptance and Commitment Therapy (Babcock et al, 2016; Zarling, Bannon, & Berta, 2017).

Well-designed qualitative studies may be quite valuable in opening up new areas of investigation, or shed light on the discrepancies and contradictions in the extant body of quantitative research findings, as is the case with IPV perpetrator treatment. A promising new area of research has come from in-depth interviews with BIP clients, who have provided valuable insights into how facilitators can better motivate and engage them in the group process. Specifically, they want facilitators who are genuine and humble; who care about them and exhibit the kind of non-judgmental stance characteristic of MI; and who maintain a safe but working group environment in which facilitators are willing to challenge abusive behaviors in respectful ways. They also favor facilitators who have knowledge and expertise about IPV and able to provide information and tools with which to change (McGinn, McColgan, & Taylor, 2017; Morrison, Cluss, Hawker, Miller, George, Bicehouse, Fleming, & Chang, 2019).

Facilitators would seem to be in agreement, as found in qualitative studies using in-depth interviews at various program sites (Chovanec, 2012; Roy, Brodeur, Labarre, Bousquet, & Sanhueza, 2019; Silvergleid & Mankowski, 2006), and consensus emerged that clients do not use the tools given them if they fail to "buy in" to what the program offers:

> Neither support nor confrontation from the facilitators stood out in isolation in the program participants' accounts. Instead, some balance of both from the facilitator appeared necessary to fully engage the participants. The facilitators similarly acknowledged the role they played in the men's change process, pointing in particular to the importance of balancing support and confrontation in their approach. Support and respect were credited with creating an environment in which change was possible (Silvergleid &Mankowski, 2006, p. 146).

The Gap Between Research and Practice

Most of this new research, unfortunately, is unavailable to the average BIP agency director or group facilitator. Except for a very few scholar-practitioners with university positions, even BIPs with professional licenses typically lack access to the peer-reviewed academic journals in which reliable, up-to-date research can be found. More accessible sources of research, in the form of in-person trainings and books, and in publications and website pages of various professional mental health and victim advocacy organizations, cannot always be trusted. Hamel (2014) cites examples of misleading or false information on the web pages of the American Psychological Association, the American Association of Marriage and Family Therapists, and the National Association of Social Workers. While by no means part of a systematic study, the mistakes found are reflected in several empirical studies. Presented with identical hypothetical physical and emotional IPV abuse scenarios, with half featuring the wife

as perpetrator and half the husband, psychologists randomly selected from membership listings of the American Psychological Association rated even acts of emotional abuse as more severe when perpetrated by the husbands (Follingstad, DeHart, & Green, 2004). In a different study using hypothetical case scenarios, mental health professionals working in the field of IPV, and particularly victim advocates, deemed male-perpetrated IPV as more coercive than female-perpetrated IPV (Hamel, Desmarais, & Nicholls, 2007). Licensed mental health professionals working as therapists, mediators and evaluators in the area of family law and disputed child custody could answer less than 3 questions correctly on a 10-item quiz of basic IPV knowledge, not significantly better than a control group of first year university undergraduates (Hamel, Desmarais, Nicholls, Malley-Morrison, & Aaronson, 2009). More recently, the Hines (2014) review of fact sheets available on the websites of the National Council Against Domestic Violence, its state subsidiaries, and associated victim advocacy organizations, identified rampant false or misleading information, reflecting a bias for gendered conceptions of IPV.

To close this gap, the first author in 2015 founded an international association of IPV researchers and perpetrator treatment programs, The Association of Domestic Violence Intervention Providers (ADVIP). With over 200 members in 18 countries, the ADVIP website (www.domesticviolenceintervention.net) offers relevant scholarly research articles on the characteristics, causes, assessment and treatment of intimate partner violence, outcome studies, presentation slides from past ADVIP conferences, training videos, a quarterly podcast series featuring IPV experts on topics related to batterer intervention, discounts on scholarly journal discounts, and access to its members and the general public through membership lists and its blog pages. ADVIP also provides access to the Partner Abuse State of Knowledge Project (PASK), a 2,657-page review of the domestic violence research literature written by scholars

from 20 universities and research institutions, published in five special issues of the journal, *Partner Abuse*, making it the most comprehensive, up-to-date and reliable domestic violence database in the world (go to: www.domesticviolenceresearch.org).

Whether or not they are familiar with ADVIP, treatment providers are expected to provide the best treatment possible, so that perpetrators are held accountable and victims are protected from further abuse. There are some indications that many treatment providers, even those most committed to the gender-based Duluth model, are open to learning from their clinical experience (Pence, 1999), and willing to combine elements from different treatment models (Gondolf, 2012; Price & Rosenbaum, 2009). Given the validity of clinical insights in evidence-based intervention (see Hamel, 2014; in press), and the still-evolving search for definitive RTC-derived treatment models, the authors in 2016 decided to survey batterer intervention in the United States and Canada about their work.

The 2016 Survey of Perpetrator Programs

The 15-page North American Domestic Violence Intervention Program Survey (NADVIPS), was sent out via e-mail and postcard invitations to 3,246 BIPs. In addition to questions on program characteristics such as theoretical orientation, treatment approaches, and provider and client demographics, it included questions regarding provider knowledge of IPV risk factors and dynamics, case management and cooperation with other stakeholders, how they handle difficult clients, and the extent to which they are willing to question or supplement state standards in order to improve treatment efficacy.

A total of 238 respondents completed the NADVIPS (Cannon, Hamel, Buttell, & Ferreira, 2016). The majority ((87.4%) reported to be Caucasian, and for the most part well-educated (59.4% having Masters level degrees), with an average 8 years of clinical experience.

As predicted, nearly all of the programs delivered their perpetrator services via the modality of group (97.3%), mostly to male offenders (83%). Similar to findings from previous surveys (e.g., Price & Rosenbaum, 2009), more respondents endorsed the gendered/feminist Duluth model (35.6%) than CBT (29.1%), and only 7.1% said they used Motivational Interviewing. Still, regardless of primary theoretical orientation their curricula included important information and skill components reflective of an eclectic approach, such as the nature of power and control and the effects of IPV on children; and ways to better manage emotions, increase self-awareness, let go of pro-violent attitudes, communicate effectively and resolve interpersonal conflicts. Furthermore, many respondents indicated that they provide ancillary services (e.g., substance abuse counseling, victim services) and, on the whole, expressed satisfaction with other stakeholders and their coordinated community response to IPV.

When asked to imagine having to cope with hypothetical scenarios involving difficult group situations (e.g., a group member who tries to dominate, or claims that the legal charges against him/her were false or exaggerated), respondents overwhelmingly recommended measured, clinically-sound interventions in line with accepted group therapy practices (Corey, Corey, & Corey, 2010; DeLucia-Waack, Kalodner, & Riva, 2014; Hamel, in press). The average program intake reported, 90 minutes, would seem to be sufficient. Given that state BIP standards reflect political interests far more than social science research or sound clinical experience (Maiuro & Eberle, 2008), it is noteworthy that a majority of survey respondents (52.4%) said they are "sometimes," "often," or "always" willing to supplement those standards; and 63.9% indicated that they adapted their written curriculum to the needs of clients rather than deliver a strictly "one-size-fits-all" lesson plan.

On the other hand, respondents demonstrated a lack of accurate knowledge on IPV in some key areas. For example, among the most salient risk factors for perpetration are having an aggressive personality, being in a high-conflict or abusive relationship, and being unemployed (Capaldi, Knoble, Shortt, & Kim, 2012), yet the percentage of respondents who considered these to be "very important" was 33.3%, 33.6%, and 21.6%, respectively. Additionally, 86.5% said that it is men who initiate physical acts of IPV (actual rates are closer to 50%), and 80.3% indicated that male-perpetrated IPV is motivated by a desire to dominate and control, compared to the 23.9% who cited this motive for female-perpetrated IPV (the percentages are comparable across gender; Langhinrichsen-Rohling & McCullars, 2012).

The Current Study

Results from our 2016 survey found misinformation (e.g., lack of knowledge about violence perpetration rates by gender) regarding IPV to be associated with lesser education and adherence to Duluth/feminist models. Less educated providers possibly lack adequate training in human development and personality and empirical research principles and are prone, therefore, to adhere to whatever treatment model is most dominant, which in the case of IPV is the Duluth model. Other explanations are possible, however, and we therefore decided to conduct a follow up survey, the Domestic Violence Perpetrator Treatment Survey, to investigate why this is so, and how willing treatment providers might be to expand their knowledge base and increase treatment effectiveness.

Although much of the current study should be considered exploratory, we can suggest some very general and tentative hypotheses, based on findings from our 2016 survey, as well as findings cited above on the pervasiveness of IPV misinformation among mental health professionals and victim advocates. First, we expect that the majority of providers will say that

they obtain their training from other providers and victim advocates, or from books and additional sources such as the internet, rather than from scholarly journals. It is expected that the majority will agree with the APA definition of evidence-based practice, but more will favor clinical experience in comparison to empirical research findings. Most will find the ADVIP web pages beneficial, in particular the blog pages and other networking opportunities, as well as the podcast series. No prediction is made about the extent to which they value the various research pages, nor their interest in working with researchers. Overall, we predict that most providers will present as eager to learn, and open to new information.

Method

The Domestic Violence Perpetrator Treatment Survey (DVPTS) was a 69-item questionnaire with mixed closed and open-ended questions sent to BIP directors, IPV scholars, mental health professionals, victim advocates and affiliated justice personnel mostly in the U.S. and Canada, as well as from international organizations. Both electronic and physical addresses were collected over a period of several years, in part from state Coalitions Against Domestic Violence, various government agencies (i.e., Batterer Intervention Services Coalition of Michigan's online listing), and the ADVIP listserv. Treatment providers and affiliated IPV personnel over the age of 18 were invited to participate in the study. Follow up emails were sent every two weeks for the six weeks that the survey was open to enrollment. Of the emails sent, 1,695 were opened. A total of 411 respondents completed the survey. The survey was administered electronically through a third party, Qualtrics, in order to maintain anonymity of responses.

Response Rate

Anticipating a high non-contact rate, given the multi-year collection of these addresses and the high turnover rate of BIPs personnel (Price & Rosenbaum, 2009), invitations were sent out to 11,500 e-mail addresses. Although only 1,695 e-mails were opened, indicating a non-contact rate of approximately 85%, the number of opened e-mails is a better measure to calculate response rate than the number initially sent. Similar concerns persist for physical addresses. For non-contact rates for mailed postcards, we use the American Association for Public Opinion's Research's (AAPOR) conservative estimate of 85%. The ratio of responses to emails opened generates a response rate of around 24%, which is in line with comparable types of studies (i.e., Price and Rosenbaum, 2009). The overall completion rate, calculated by the number of people who completed the survey divided by the number of people who began the survey, is very high at 93.84%. Respondents came from all 50 states except Nebraska, New Mexico, North Dakota, Rhode Island, and Wyoming. From the ADVIP listserv there are also respondents from across the world including the UK, Ireland, Australia, Germany, Canada, Cairo, Singapore, Taiwan, Kenya, Guam, and South Africa.

We began the survey with some of the same questions from the 2016 survey, on respondent demographics and program characteristics. However, given that the 2016 survey did not mention evidence-based practice directly, the new survey instrument was designed by the research team to ascertain respondents' views on evidence-based practices broadly, and MI specifically, and to identify specific sources and types of training they utilize, and in which areas of IPV would they like more research to be conducted. In addition, respondents were directed to the ADVIP website to evaluate the utility of the website as one avenue of communicating evidence-based practices. Respondents were also invited to suggest other means by which evidence-based practice could be advanced, and asked about the possibility of working directly

with research scholars. The survey was sent out not only to BIPs, but also to victim advocates, and IPV researchers, as well as mental health professionals who work with a broader range of clients and modalities, to ascertain if there are differences among them.

Purpose of the study

Just over half of all respondents surveyed identified as domestic violence treatment providers, or 59.61% of 411 respondents (N=245). Of those surveyed 8.76% (N=36) identified as researchers. Quantitative data were analyzed to reveal descriptive statistics. In this article, we report results from the domestic violence perpetrator treatment providers only (data from the researchers will be published separately.)

Results

Respondent Demographics

Information on respondent demographics can be found in table 1. Among the respondents, 35.27% were the director of the entire agency (N=103), whereas 26.71% (N=78) reported being a group facilitator, and 16.78% (N=49) reported being the director of the domestic violence perpetrator program. Another 21.23% (N=62) endorsed the Other category for their position. When specified, these positions included social worker, clinician, supervisor, therapist, counselor, group facilitator, and private practice. Regarding licensure, 33.92% of respondents (N=77) said they were a licensed professional counselor, 17.18% (N=39) reported having a LCSW, 11.89% (N=27) reported being a clinical psychologist, 10.57% (N=24) reported being a marriage and family therapist, and 1.32% (N=3) reported being a registered nurse. Of respondents, 25.11% (N=57) said they were unlicensed.

The average age range of respondents was 50-60 years. Most (65.89%; N=253) identified as female, 33.85% (N=130) as male, and 0.26% (N=1) as Other. A majority (74.28%;

N=283) identified as white, 8.66% (N=33) as Hispanic or Latino, 8.14% (N=31) as African American, 2.36% (N=9) as American Indian or Alaska Native, 2.1% (N=8) as Asian, 0.52% (N=2) as Hawaiian or Pacific Islander, and 3.94% (N=15) as Other. When asked to specify this Other category, respondents reported biracial, Arab ethnicity, African, pan, Indian American, Native American, Hispanic European, prefer not to answer, Latina European, Jewish, Canadian, and European. With respect to educational attainment, 52.99% (N=204) reported having a MA, MSW, or MS, 18.7% (N=72) a PhD, DSW, or PsyD, 15.06% (N=58) a bachelor's degree, 3.9% (N=15) some college, 1.82% (N=7) an associate's degree, 1.04% (N=4) an MD, 0.78% (N=3) high school completion or equivalent, and 0.26% (N=1) indicated having obtained a technical degree. Of respondents, 5.45% (N=21) chose the Other category for educational attainment. When asked to specify, they wrote M.ED/JD, CADC/CAMSII, certification in family therapy, DPA, MBA, JD, LISAC, Post Master's certificate, MDIV, LCDC, and domestic violence certification.

Program Information, Structure and Content

Results under this category are listed in table 2. Just over half of all respondents surveyed identified as working in the role of domestic violence treatment provider, or 59.61% of 411 respondents (N=245), while 8.76% (N=36) identified as a domestic violence researcher, and 8.27% (N=34) as a victim advocate. Of the remaining sample, 23.36% identified as Other (N=96). We asked respondents to specify this Other category with responses that range from family therapist, psychiatrist, probation officer to domestic violence survivor. Of those surveyed, 50.43% of respondents (N=116) reported being in private practices, 28.7% (N=66) reported being part of a larger counseling or social service agency, 4.35% (N=10) indicated they were part of a battered women's shelter, and 16.52% (N=38) reported being in another type of agency.

When asked to specify this Other category, respondents reported being part of a small agency, community corrections, IPV transitional counseling and prevention education, hospital, private probation, and non-profit organization.

When asked whether or not their program provides treatment for people who have perpetrated some form of intimate partner abuse, 91.74% (N=211) reported their program did offer such programs and 8.26% (N=19) reported they did not. Those whose programs did offer treatment for abusers were asked a series of questions on the kinds of treatment provided. When asked to estimate the percentage of clients being treated for some form of partner abuse, 40.47% (N=87) estimated 80-100%. 11.16% (N=24) estimated 60-79%, 12.56% (N=27) estimated 40-59%, 16.28% (N=35) estimated 20-39%, and 19.53% (N=42) estimated 0-19% of their clients were receiving treatment for partner abuse.

On average 61.51% of clients were seen in the modality of group, 21.76% in individual therapy, and 7.77% in couples or family therapy (note percentages do not sum to 100 because these are averages across all respondents). Half (53.99%; N=115) of respondents estimated 75-100% of their clients had been court-mandated to treatment, 13.15% (N=28) estimated 60-74%, 6.1% (N=13) estimated 45-59%, 6.1% (N=13) estimated 30-44%, 4.23% (N=9) estimated 15-29%, while 16.43% (N=35) estimated that 0-14% were court-mandated to treatment. The majority of respondents (60.38; 128) reported 10 mor more years working with this population.

When asked to identify the primary domestic violence group treatment orientation, 31.1% (N=65) reported CBT, and 30.62% (N=64) reported Duluth or feminist/gender-based approach. Of respondents, 11% (N=23) said they used psychodynamic approaches and 27.27% (N=57) reported the Other category. When asked to elaborate, respondents cited a combination of CBT and feminist/gender-based approaches, ACT therapy, SAFE, trauma-informed CBT, family

systems, some combination of Duluth, Emerge, and CBT, integrative psychotherapy, CECEVIM (a culturally appropriate model for Latino men), psychoeducation, therapeutic, Family Peace Initiative, Dialectical Behavior Therapy, Brief solution focused, the Wexler and Welland Model, MRT, and Adlarian.

When asked how often respondents' programs use Motivational Interviewing or a similar client-centered approach, 30.05% (N=64) reported always, 41.31% (N=88) very often, 19.72% (N=42) sometimes, 5.16% (N=11) rarely, and 3.76% (N=8) never.

Domestic Violence Training

This section (see table 3) focuses on the responses given to a series of questions intended to ascertain what if any domestic violence training the providers receive. In order to more fully understand the gap in use of evidence-based practices, we aimed to identify if training might be a viable pathway for translating evidence-based practices and to increase the use of such practices.

Respondents reported the number of hours of domestic violence-related professional training they receive on average. Just over a third (36.92%; N=120) reported having 16 or more hours annually on average, 24.62% (N=80) reported 9-16 hours, 13.85% (N=45) reported 5-8 hours, 16.31% (N=53) reported 1-4 hours, and 8.31% (N=27) reported zero hours of training. Of the domestic violence-related professional training respondents received each year, 4.04% (N=13) reported 16 or more hours were conducted online, 10.87% (N=35) reported 9-16 hours, 18.63% (N=60) reported 5-8 hours, 32.3% (N=104) reported 1-4 hours, and 34.16% (N=110) reported 0 of their training hours were conducted online. Among respondents who received their domestic violence-related professional training hours received in person, 19.69% (N=63) did 16 or more hours, 24.69% (N=79) 9-16 hours, 18.44% (N=59) 5-8 hours, 19.06% (N=61) 1-4 hours, and 18.13% (N=58) reported zero training hours completed in person.

Respondents were asked from where they typically received their in-person domestic violence-related professional training. Among them, 23.96% (N=75) indicated getting their training from a BIP representative, 17.89% (N=56) from a local battered person's shelter or other victim advocacy agency, 16.61% (N=52) from a non-BIP mental health professional, and 41.53% (N=130) reported their in-person training came from another source. When asked to specify, respondents cited state domestic violence associations (i.e., Connecticut Coalition Against Domestic Violence; CCADV), conferences (i.e., Institute on Violence, Abuse and Trauma's annual summit), mental health consultants, a mix of BIP and victim advocates, reading academic literature, nonprofit domestic violence service providers (i.e., National Network to End Domestic Violence, NNEDV), state mandated trainers, universities, state programs, courts (i.e., Association of Family and Conciliation Courts), national experts, batterer intervention services (i.e., Batterer Intervention Services Coalition of Michigan), state offender management board, and local outreach organizations.

In addition to training hours, we asked questions regarding domestic violence-related readings and use of online resources to better understand where providers get the latest available research and information on evidence-based practices. For example, we asked respondents how many hours per year on average they spend reading about domestic violence (e.g., research, causes, dynamics, consequences, prevention, etc.). Of respondents, 30.86% (N=100) reported spending 40 or more hours reading about domestic violence, 23.46% (N=76) reported 21-40 hours, 21.6% (N=70) reported spending 11-20 hours, and 24.07% (N=78) reported spending 0-10 hours per year on average reading about domestic violence. Respondents said that on average they spend 20.69% of this time on books, 27.37% on peer-reviewed scholarly domestic violence-related journals, 34.68% on online informational pages, and 5.95% of this time on some other

reading outlet (e.g., mental health websites, relationship resource books, magazine articles, psychological/legal journals, government publications, agency trainings, documentaries, conferences, webinars, coalition webpages, police reports, and web videos).

We followed up our questions about reading time and sources with a question on online resource usage over the past year. Among the respondents, 30.33% (N=219) cited mental health websites (e.g., Psychology Today), 20.19% (N=218) professional organization websites (e.g., American Psychological Association), 27.84% (N=201) the National Council Against Domestic Violence, and 11.63% (N=84) said they used some other websites.

When asked to specify alternative online resources used, they cited domestic violence specific websites, academic resources (i.e., Association for Contextual Behavioral Sciences), , twelve-step websites (i.e., Narcotic Anonymous 12-steps), mindfulness websites, trauma treatment websites (i.e., National Child Traumatic Stress Network), academic search engines (e.g., Google Scholar), federal websites (i.e., Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH), National Institute of Justice, (NIJ)), domestic violence agency websites, law enforcement, National Anger Management Association, conferences, state domestic violence organizations, Stalking and Harassment Assessment and Risk Profile (SHARP), court websites, IVAT, legal research journals, state domestic violence websites (i.e., CCADV, North Carolina Coalition Against Domestic Violence, San Diego Domestic Violence Council, Tennessee Coalition Against Domestic Violence, Texas Council on Family Violence,), national and international provider associations (i.e., ADVIP), national domestic violence organizations (i.e., Battered Women's Justice Project), Domestic Violence Offender Management Board, online discussion groups, Association of Forensic Counselors, , National

Association of Social Workers, online journals, attorney general offices, National Domestic Violence Fatality Review Initiative, Duluth model websites, and news media websites.

Lastly, we asked respondents about the minimum number of continuing education units (CEUs) per year they thought should be required for all court approved domestic violence perpetrator treatment programs. Trainings that provide CEUs are thought to be more reputable than those that do not, because CEU providers must first demonstrate some expertise in the subject matter of the training, typically be licensed and have their training approved by a licensing board or similar organization. Of respondents, 28.16% (N=78) reported 15 or more CEUs per year, 32.85% (N=91) 10-14 CEUs, 22.74% (N=63) 5-9 CEUs, 14.8% (N=41) 1-4 CEUs, and 1.44% (N=4) reported 0 CEUs per year.

Views on Evidence-Based Practices

We included a series of questions in order to gain a sense of respondents' familiarity and views on evidence-based practices (see table 4). First, we asked how much they agreed with the APA's definition of evidence-based practices. The APA defines evidence-based practice as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences" (APA, 2006, p. 273). We found that 41.37% (N=127) of the sample strongly agreed and 40.72% (N=125) agreed with the APA definition, while 13.36% (N=41) indicated they neither agreed nor disagreed with the definition. A small number (4.56%; N=14) disagreed with the APA definition, and no respondents strongly disagreed with the definition.

We then asked respondents whether they thought the APA definition for evidence-based best practices should be based on other criteria. A sizeable minority (17.95%; N=14) of the sample responded that best practices should be based only, or mostly on, clinical experience.

The same number reported that best practices should be based only, or mostly on, recommendations from victim advocates, and yet again the same number said they should be based on findings from the research literature. Somewhat less than half (46.15%; N=36) endorsed the Other category. When asked to elaborate, respondents said that best practices needed to be based on experiences of domestic violence survivors, that evidence-based practices will only be as effective as the therapists delivering them (i.e., a dominating administrator who dominates therapists will hinder the effectiveness of evidence-based practices), such practices should be based on education and personal experience, interwoven with patient, clinical expertise, research and victim advocates, developing novel approaches to be tested and evaluated, community-based, feedback from facilitators, and rigorous well-developed theory.

When asked to estimate the number of total hours they have spent reading about or taken trainings on evidence-based practice in the past year, 19.02% (N=58) of respondents indicated 15 or more hours, 9.18% (N=28) 11-14 hours, 18.69% (N=57) 6-10 hours, 40.33% (N=123) 1-5 hours, and 12.79% (N=39) reported spending zero hours. When asked how useful these resources had been to providers' work with domestic violence clients, 19.16% (N=55) reported they were extremely useful, 40.42% (N=116) very useful, 27.18% (N=78) moderately useful, 8.36% slightly useful, and 4.88% (N=14) reported such sources were not at all useful. When we then asked respondents how important evidence-based practices were to their work with domestic violence clients, 44.04% (N=13) indicated that these practices were very important, 35.43% (N=107) said they were important, and 14.24% (N=43) reported they were fairly important. Evidence-based practices were slightly important or not important to only 5.3% (N=16) and 0.99% (N=3) of respondents, respectively.

We further asked respondents to report on what they thought could help advance evidence-based treatment. (Note, respondents were able to choose more than one answer choice.) About a third (34.47%; N=121) indicated that revising the state standards to mandate that all perpetrator programs be evidence based would advance evidence-based treatment, and more than half (53.56%; N=188) suggested that requiring the initial certification to become a BIP provider be conducted by someone with substantial knowledge of domestic violence causes, consequences, assessment and treatment would effectively advance evidence-based treatment. When asked for their own recommendations for advancing evidence-based treatment, respondents suggested the following: align programs and state standards with legal definitions of domestic violence, including IPV and family violence; revise state standards to allow couples therapy; better understand institutional paradox; take into consideration cultural and ethnic values and beliefs; provide trainings to service providers on how research informs practice; develop early intervention and prevention strategies; assess perpetrator programs' effectiveness by qualified, independent researchers; use standardize assessment tool to identify appropriate need and risk factor in order to provide appropriate treatment for courts sentencing perpetrators, instead of a one size fits all model; encourage local, state, and federal funding to train and support these programs; develop national registry of programs; and, provide oversight of organizations to prevent misappropriation of public and private funds.

Association of Domestic Violence Intervention Programs

In order to understand what gaps may exist between available research on domestic violence, broadly, and evidence-based practices, specifically, we asked a series of questions on the usability of ADVIP's website (see table 5). ADVIP is the only international association of its kind that seeks to bring together experiences, insights, and issues of providers with those of

researchers, along with social science data from published, peer-reviewed studies. In capturing the effectiveness of ADVIP's website, we sought to measure how ADVIP may better serve providers in order to bridge the gap between research and practitioners. Respondents were then asked to evaluate utility of the seven main content areas of the ADVIP website. These content areas, including Program Research, Member Directory, Blog/News, Podcasts, *Partner Abuse* State of Knowledge Project, Member Discounts on Peer-Reviewed Journal Subscriptions, and ADVIP 2018 World Conference Findings, each correspond with work ADVIP does to promote the cross pollination of cutting-edge research and practitioners. For instance, Partner Abuse State of Knowledge Project are several reviews of important areas of study related to partner abuse and domestic violence. These research reviews are available to practitioners and researchers alike to inform them of the latest available research and future directions.

Of respondents, 67.06% (N=171) reported that Program Research, a page with links to literature reviews on domestic violence intervention programs globally, was extremely or very useful, and 27.06% (N=69) found it moderately useful, while 4.31% (N=11) found Program Page to be only slightly useful and 1.57% (N=4) not useful at all. Regarding the Member Directory pages, a list of providers and researchers from across the world, 39.93% (N=101) of respondents found it to be extremely or very useful, 35.18% (N=89) moderately useful, 17% (N=43) slightly useful, and 7.91% (N=20) found it not useful at all. Among the respondents, 54.94% (N=139) found the Blog/News page, a page dedicated to latest scholarly research, program descriptions, trainings and resources, and policy and politics, to be extremely or very useful, 28.85% (N=73) moderately useful, and 11.86% (N=30) slightly useful. A smaller percentage (4.35%; N=11) indicated they found it not at all useful. When asked to rate the Podcast pages, with links to podcasts conducted on various areas of interest for both domestic violence researchers and

practitioners, 54.58% (N=137) of respondents said they found them extremely or very useful, 26.29% (N=66) moderately useful, 14.74% (N=37) slightly useful, and 4.38% (N=11) said that the Podcasts pages were not at all useful.

A large majority of respondents (65.2%; N=163) reported that the Partner Abuse State of Knowledge Project (PASK), the full 2,657-page report and summaries on domestic violence research, was extremely or very useful. Among the rest, 23.2% (N=58) found the PASK page moderately useful, while 9.6% (N=24) found it slightly useful and 2% (N=5) not at all useful. Of respondents, 52.22% (N=129) found the Member Discounts on Peer-Reviewed Journal Subscriptions, including 40% off leading research journals, to be extremely or very useful, 24.7% (N=61) moderately useful, 14.17% (N=35) slightly useful, and 8.91% (N=22) not at all useful. When asked about the ADVIP 2018 World Conference findings pages, 54.7% (N=134) of respondents found them extremely or very useful, 29.8% (N=73) found these moderately useful, 12.65% (N=31) said they were slightly useful, and a smaller number (2.86%; N=7) said they were not at all useful.

Lastly, respondents were asked for additional ways to improve ADVIP in order to better serve the needs of the provider population. Recommendations included: adding advocates in local government, training events, more local or state conferences, publication of a newsletter, community outreach, more user-friendly website with larger print, CEU credits, more free online trainings, proven interventions, resources to share with the general public, and more videos and handouts.

Working with Researchers

In order to ascertain the possibility of collaborations with IPV researchers as a mechanism for relaying evidence-based practices and for researchers to garner insights from

providers, we asked the providers a series of questions on working with IPV researchers (see table 6). Although a majority of the sample (70.82%; N=216) said they had never participated in an empirical study, of those who did 70.79% (N=63) reported being extremely or somewhat satisfied with the experience and only 5.6% (N=5) reported being dissatisfied. When asked how likely they would be to work with domestic violence researchers in the future, 74.49% (N=219) reported they would be extremely or somewhat likely to do so. A minority said they were unlikely (7.14%; N=21), or neither likely nor unlikely (18.37%; N=54), to work with a researcher in the future.

In order to better understand research priorities important to practitioners, we asked respondents to rank areas of domestic violence that they would like research to focus more studies on. Of respondents, 21.53% (N=59) reported prevention as their top ranked choice for IPV research, with 6.93% (N=19) ranking it as a second choice. Among the rest, 13.14% (N=36) indicated prevalence rates of physical violence as their first topical choice, with 8.39% (N=23) ranking it second. Effective treatment strategies were ranked as the top choice by 12.77% (N=35) of respondents, with 10.95% (N=30) ranking it second. Each research topic of abuse dynamics and context of abuse (i.e., who initiates violence) were selected as first choice by 7.3% (N=20) of the sample. Abuse dynamics was selected as a second major research area by 7.66% (N=21) and context of abuse was selected as a second ranked choice by 7.3% (N=20) of the sample. Prevalence rates of non-physical violence was the first choice for IPV research by 6.2% (N=17) of the respondents, while 10.95% (N=30) selecting it as a second top choice. Only 5.84% (N=16) of respondents ranked impact of domestic abuse on children as the first choice for IPV research, with 6.57% (N=18) ranking it second. Even less (5.47%; N=15) ranked assessment as the top priority for IPV research with 9.12% (N=25) ranking it second.

Respondents reported their first and second ranked choices for other research topics. Domestic abuse among ethnic and religious minorities was the first choice among 4.74% (N=13) and the second choice by 4.01% (N=11) of respondents; IPV causes and risk factors of IPV were ranked by 4.38% (N=12) as their first choice, and 9.12% (N=25) as their second choice. The impact of domestic abuse on victims and group treatment were ranked as their top priority for IPV research by the same number of respondents (2.92%; N=8), while domestic abuse on victims was ranked as a second choice by 5.47% (N=15) of respondents, and group treatment ranked as a second choice by 3.65% (N=10). Of respondents, 2.19% (N=6) chose IPV among LGBT populations and individual treatment as their top choice. LGBT abuse was a second priority by 4.74% (N=13) of respondents, with 2.92% (N=8) reporting individual treatment as their second ranked choice. Lastly, only 1.09% (N=3) ranked research on couples and family treatment their top priority, with 2.19% (N=6) ranking it second.

Discussion

This article serves as a follow up from the 2016 survey conducted by the research team and is aimed at generating information on the educational background of BIP treatment providers, where they receive their training in IPV and for continuing education, their use of Motivational Interviewing, their view on Evidence-Based Practice, their views on the value of empirical research and their interest in working with a researcher, and their views on ADVIP. In terms of the demographic make-up of respondents, one third of the study sample identified as being the director of the agency, with respondent positions ranging from social worker, clinician, supervisor, therapist and counselor. Most of the respondents identified as being female (60%) and white (75%) with most being between 50-60 years of age. Roughly 75% of respondents identified as being licensed, suggesting that the overwhelming majority of treatment provider

respondents are governed by a regulatory board. This is an interesting finding in light of the mixed results we found related to incorporating EBP into BIPs (see below). In this respect, it might be profitable to advocate that state regulatory boards move towards requiring EBP CEUs for treatment providers.

Program Information, Structure & Content

Regarding the survey sample over half of all respondents surveyed identified as domestic violence treatment providers, or 59.61% of 411 study respondents (N=245). Regarding the level of education of the study sample, there was a slight decrease between the respondents from 2019 and the respondents from 2016, with the 54% of the 2019 respondents reporting a graduate degree (i.e., having an MA, MSW, or MS) versus 59.4% of respondents in the 2016 survey sample. The slight change can be attributed to several factors, not the least of which is response samples being different, but there is a high level of turnover in BIPs, which also might explain the difference.

Interestingly, the 2019 survey found a significant decrease regarding the group setting format as form of treatment, with a 35% drop in comparison to the result of the 2016 survey, with an average, of 61.5% of clients being seen in a group setting in 2019, versus 97.3% for 2016. This significant decrease may be attributed to clients receiving individualized care. It is important to note that our 2016 survey sample consisted entirely of BIPs who normally work with groups only, whereas the 2019 sample also consisted to mental health professionals who identified as working with IPV perpetrators but were not necessarily BIPs. Given the importance of client preferences in research on best practices, the use of an individual therapy by nearly a quarter of providers is highly encouraging. Less encouraging was the meager 7.7% of respondents who reported the use of the couples or family therapy formats. As mentioned

previously, couples counseling has been found through randomized control trial (RCT) research to significantly lower recidivism rates among couples experiencing situational violence. The underuse of this format may be partially explained by its prohibition in most state standards for court-mandated clients, and the 54% of respondents with court-mandated individuals comprising 75% or more of their client base, as well as the lack of licensure by 25% of respondents.

The theoretical orientation of the intervention model remained relatively consistent between the two survey administrations. In 2016, 29% identified as adherents to CBT and 35% as adherents to Duluth, while the numbers in 2019 were 31.1% CB and 30.62% Duluth. However, over a quarter (27%) indicated their theoretical orientation was Other, and many respondents reported using mixed models, with elements of both Duluth, CBT and additional intervention combinations. Finally, the overwhelming majority of respondents (71%) reported "always" or "very often" using motivational interviewing with their clients. This particular finding would seem to challenge some of the more rigid psychoeducational approaches, and dovetails nicely with the tendency towards eclecticism and mixed models as found in both the 2016 and current surveys. The research team recommends this as a key area of additional exploration.

Training

Roughly 36.9% (N=120) of respondents reported receiving 16 or more hours annually of average of domestic violence-related professional training and 25% reported receiving 9-16 annual hours of IPV training. Given that most of the respondents are licensed mental health providers, this represents a significant portion of their continuing education requirements. This finding is encouraging and suggests that the respondents working as IPV treatment providers are actively trying to stay abreast of current trends in the field. Peer-reviewed journals were cited by

more than a quarter (27%) of the respondents, not ideal in terms of truly EBP, but an encouraging finding given that journals are mostly accessible to university professors and students. More troubling is the finding that 24% of respondents get their training from a BIP and an additional 18% get their training from a battered women's shelter or advocacy agency. If these respondents are only looking to the field for training, there is a very real danger that they will simply reify what they already know and believe to be happening in IPV cases. This might serve to inhibit exposure to new information and research that might stimulate respondents to be critical of some of their policies or practices, which has a negative effect on client outcomes. The recommendation from 60% of respondents that providers receive at least 10 CEUs per year, while seemingly a positive finding, should therefore be considered in light of reported training sources.

Views on EBP

We expected that the majority of the sample would agree with the American Psychological Association's definition of evidence-based practice. Based on our findings, roughly 82% (N=252) strongly agreed or agreed with the definition. About 60% found EBP materials and information "extremely useful" or "very useful," and nearly 80% found EBP "very important" or "important" in their work with perpetrators. However, when asked about alternative ways to define EBP, less than 20% favored empirical research findings, and twice as many endorsed clinical experience or recommendations from victim advocates. This discrepancy between endorsing EBP and then not also favoring research is hard to reconcile. One possible explanation is that many respondents might endorse the definition but lack formal training on the concept of evidence-based practice or that evidence-based practice does require a lot of time to implement and execute. Evidence for this explanation can be found in the fact that 52% (N=162)

of the sample has spent less than 5 hours reading evidence-based practice related materials, despite the majority of the sample (94%) indicating that evidence-based practice is relevant to their work with domestic violence clients.

To further advance evidence-based practice, only 34.47% (N=121) of respondents said that state standards should be revised to mandate that all BIP be evidence-based, and 53.56% (N=188) recommended that the initial certification to become a BIP provider be conducted by someone with substantial knowledge of domestic violence causes, consequences, assessment and treatment. These two findings appear to be somewhat contradictory, and may be explained by a poor understanding of what constitutes EBP. As mentioned previously, in-depth interviews with group facilitators find them in accordance with client preferences in enhancing motivation and the group process, and implementing some of the common factors from psychotherapy outcome studies as well as MI techniques found effective by randomized control studies to increase group engagement and lower recidivism rates. It should be noted that our previous national survey found facilitators to be well versed in ways to effectively manage difficult group situations, and willing to implement a number of eclectic interventions. The 2016 survey also found a majority to supplement state BIP standards as necessary. Together, these findings suggest that many facilitators are already implementing some form of evidence-based practice. Respondent responses in the current survey might very well reflect a concern that codification of EBP would unduly constrain their approaches to treatment (e.g., that some unfamiliar curriculum might be imposed upon them by bureaucrats with no front-line clinical experience). These questions certainly warrant further exploration.

Views on ADVIP and Working with IPV Researchers

Prior to conducting the survey, we believed that most respondents would find the ADVIP web pages beneficial, with the blog pages, podcast series and other networking opportunities as being most beneficial. Somewhat surprisingly, most highly-endorsed were the two main sets of research pages, Program Research and PASK, found to be "extremely or very useful" by 94% and 88% of respondents, respectively. Generally, however, a majority of respondents found the resources on the ADVIP web page to be of extreme value to their daily practice, including the networking opportunities provided through the blog, the quarterly podcast series, discounts on peer-reviewed journal subscriptions, conferences and trainings, and presentation slides from the 2018 ADVIP conference. Least-endorsed was the member directory, indicating that respondents either found the blog pages a sufficient means to network, and/or found the research and other resources more important.

Various recommendations were suggested on ways ADVIP can better meet the needs of the provider population. Some (e.g., adding advocates in local government, more local and state conferences) would appear to be longer-term projects, and perhaps not feasible at all, without a substantial increase in monetary resources and member commitment and interest. The others could be addressed more immediately. All of them will be brought up for discussion among members of the Executive Board, and at the 2020 ADVIP international conference, and as a whole indicate a desire for ADVIP to take expand as an organization and perhaps take on a greater role in the broader domestic violence community.

Although most respondents (71%) indicated that they have never participated in a study with a domestic violence researcher, of those who have 71% indicated they had a positive experience. Perhaps more importantly, 75% of respondents indicated they would be interested in collaborating with a domestic violence researcher, which bodes well for the notion of increasing

the field's exposure to EBP, and the continuing role of ADVIP. While provider-researcher cooperation has from the outset been a foundational mission of the organization, it would seem worthwhile for ADVIP to explore additional ways to bring the two groups together.

Conclusions

This study provides a platform to gain a better understanding of how BIPs operate and what the current strengths and gaps exist on the front lines of perpetrator treatment in our communities. The results of our survey provide additional evidence that individuals working in the field of perpetrator treatment have much more in common than what traditional treatment models would predict. In answering the question posed in the title of this article, our reporting sample would indicate that providers are indeed ready for evidence-based practice, despite some confusion around the meaning of this term, although it should be noted that our survey may not be representative of all BIPs and others working with IPV perpetrators. The study questionnaire, while not excessively long, did require some time and effort and this may have dissuaded some potential respondents from participating – e.g., providers with little interest in improving their skill-set, those with a predisposition to regard EBP negatively, skewing the results in such a way that we are overestimating the acceptance of EBP among BIPs.

Clearly, clinical experience is an important component of EBP, and the 10+ years reported by a majority of respondents may partially explain why the extant research on facilitators finds them to be responsive to client preferences, with a strong grasp of group process factors. Over time, even poorly-trained clinicians gain competence, if they are motivated to improve their skill set, and open to learning. However, establishing a working alliance with any particular client, and engaging group members in such as way that they truly "buy in" to what the program expects from them takes more than being a nice guy (or gal). Common factors such as

empathy and genuineness are important; but what if a program's treatment philosophy, its curriculum and what risk factors it addresses do not align with a client's particular needs and preferences? A man with strong egalitarian views on male-female relationships, for example, may balk at fully committing to a traditional Duluth program, if he feels misunderstood or cannot identify with the other group members? If what he needs is mostly emotion-management skills and these are only minimally addressed in group, he is likely to view the facilitator as insufficiently knowledgeable about IPV, and more importantly, will not acquire the skills with which to overcome his violence.

To be maximally successful in helping clients change, providers need to know what they don't know, much of which can only be found from empirical research sources. This is especially true for successful diagnosis and assessment-based treatment considerations, crucial in the implementation of RNR principles regarding length and type of treatment. Input from victim advocates and other treatment providers may be enormously helpful, but a basic understanding of the research literature provides a framework for providers to sort out what is merely opinion and what actually works, and reduces the likelihood of overconfidence and confirmation bias. There is a need for more studies both on the common therapeutic elements among programs as well as research on the efficacy of differential treatment strategies, based on the particular treatment needs of various populations. Greater attention should be paid to the development of culturally relevant and appropriate interventions for underserved populations, including people of color, female offenders, ethnic minorities, and LGBTQI populations, and how these can be integrated into EBP.

Areas of future research should focus on additional ways to make relevant research findings available to front-line providers and expand collaborative research and networking

opportunities between not only perpetrator program providers and researchers, but also between these groups and other stakeholders – especially victim advocates and policy-makers – who are the most resistant to EBP. Research should examine how training opportunities can be created for providers to become better informed about on basic principles of empirical research methodology, including the differences between qualitative and quantitative data sets, and the cognitive biases and heuristics inherent in all research, particularly from findings generated from clinical experience and non-random samples. Eventually, it is hoped that these efforts will lead to the establishment of better-informed state standards in the United States.

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Table 1. Demographics

	Percent (*n*)
Agency position	
Director of agency	35.27(103)
Director of DV perpetrator program	16.78(49)
Group facilitator	26.71(78)
Other	21.23(62)
Licensure	
Licensed professional counselor	33.92(77)
LCSW	17.18(39)
Clinical psychologist	11.89(27)
Marriage and family therapist	10.57(25)
Registered nurse	1.32(3)
Unlicensed	25.11(57)
Gender	
Female	65.89(253)
Male	33.85(130)
Other	.26(1)
Race/Ethnicity	
White	74.28(283)
Latino or Hispanic	8.66(33)
African American	8.14(31)
American India or Alaska Native	2.36(9)
Asian	2.1(8)
Hawaiian or Pacific Islander	0.52(2)
Other	3.94(15)
Educational attainment	
High school degree or equivalent	0.78(3)
Technical degree	0.26(1)
Associate's degree	1.82(7)
Bachelor's degree	15.06(58)
MA/MSW/MS	52.99(204)
PHD/DSW/PsyD	18.7(72)
MD	1.04(4)
Other	5.45(21)

Table 2. Program information, structure and content

	Percent (*n*)
Provider role	
Domestic violence treatment provider	59.61(245)
Domestic violence researcher	8.76(36)
Victim advocate	8.27(34)
Other	23.36(96)
Agency type	
Private practice	50.43(116)
Part of a larger social service agency	28.7(66)
Part of a battered women's shelter	4.35(10)
Other type of agency	16.52(38)
Provide perpetrator treatment programs	
Yes	91.74(211)
No	8.26(19)
Estimated percentage of clients treated for some form of partner abuse	
0-19	19.53(42)
20-39	16.28(35)
40-59	12.56(27)
60-79	11.16(24)
80-100	40.47(87)
Treatment modality	
Group	61.51
Individual	21.76
Couples/family	7.77
Percentages of court-mandated clients	
0-14	16.43(35)
15-29	4.23(9)
30-44	6.1(13)
45-59	6.1(13)
60-74	13.15(28)
75-100	53.99(115)
Number of years working with this population	
0-3	10.38(22)
4-6	16.98(36)
7-10	12.26(26)
10 or more	60.38(128)
Primary group treatment orientation	
Cognitive Behavioral Therapy (CBT)	31.1(65)
Duluth or feminist/gender-based paradigm	30.62(64)
Psychodynamic approach	11(23)
Other	27.27(57)
Frequency of use of Motivational Interviewing/ client-centered approach	
Always	30.05(64)
Very often	41.31(88)
Sometimes	19.72(42)
Rarely	5.16(11)
Never	3.76(8)

Table 3. Domestic violence training

	Percent (*n*)
Number of hours of DV professional training on average annually	
16 or more	36.92(120)
9-16	24.62(80)
5-8	13.85(45)
1-4	16.31(53)
0	8.31(58)
Number of hours completed online	
16 or more	4.04(13)
9-16	10.87(35)
5-8	18.63(60)
1-4	32.3(104)
0	34.16(110)
Number of hours completed in person	
16 or more	19.69(63)
9-16	24.69(79)
5-8	18.44(59)
1-4	19.06(61)
0	18.13(58)
Source of respondents' training	
BIP representative	23.96(75)
Victim advocacy agency	17.89(56)
Non-BIP mental health professional	16.61(52)
Another source	41.53(130)
Number of hours spent reading about DV annually (i.e., research, dynamics, etc.)	
40 or more	30.86(100)
21-40	23.36(76)
11-20	21.6(70)
0-10	24.07(78)
Reading sources on average	
Books	20.69
Peer-reviewed academic journals	27.37
Online informational pages	34.68
Other outlet (e.g., government publications)	5.95
Online resource usage over the past year (Note: respondents had more than one answer choice)	
Mental health websites	30.33(219)
Professional organization websites (e.g., APA)	20.19(218)
National Council Against Domestic Violence	27.84(201)
Other	11.63(84)
Number of continuing education units per year should be required for DV treatment programs	
15 or more	28.16(78)
10-14	32.85(91)
5-9	22.74(63)
1-4	14.8(41)
0	1.44(4)

Table 4. Views on evidence-based practices (EBP)

	Percent (*n*)
Degree of agreement with APA definition of EPB	
Strongly agree	41.37(127)
Agree	40.72(125)
Neither agree nor disagree	13.36(41)
Disagree	4.56(14)
Strongly disagree	0(0)
EPB should be based on other criteria:	
Clinical experience	17.95(14)
Findings from the literature	17.95(14)
Recommendations from victim advocates	17.95(14)
Other	46.15(36)
Estimated total number of hours reading on or training in EBP in the past year	
15 or more	19.02(58)
11-14	9.18(28)
6-10	18.69(57)
1-5	40.33(123)
0	12.79(39)
Reported usefulness of EPB materials to practice	
Extremely useful	19.16(55)
Very useful	40.42(116)
Moderately useful	27.18(78)
Slightly useful	8.36(24)
Not at all useful	4.88(14)
Importance of EBP to respondents' work with DV clients	
Very important	44.04(13)
Important	35.43(107)
Fairly important	14.24(43)
Slightly important	5.3(16)
Not at all important	0.99(3)
What respondents indicated the following could advance EBP	
Revising state standards	34.47(121)
Initial certification by BIP provider	53.56(188)

Table 5. Association of Domestic Violence Intervention Providers website usefulness

	Percent (*n*)
Program Research	
Extremely or very useful	67.06(171)
Moderately useful	27.06(69)
Slightly useful	4.31(11)
Not at all useful	1.57(4)
Member directory	
Extremely or very useful	39.93(101)
Moderately useful	35.18)89)
Slightly useful	17(43)
Not at all useful	7.91(20)
Blog/News	
Extremely or very useful	54.94(139)
Moderately useful	28.85(73)
Slightly useful	11.86(30)
Not at all useful	4.35(11)
Podcasts	
Extremely or very useful	54.58(137)
Moderately useful	26.29(66)
Slightly useful	14.74(37)
Not at all useful	4.35(11)
PASK Project	
Extremely or very useful	65.2(163)
Moderately useful	23.2(58)
Slightly useful	9.6(24)
Not at all useful	2(5)
Member discounts	
Extremely or very useful	52.22(129)
Moderately useful	24.7(61)
Slightly useful	14.17(35)
Not at all useful	8.91(22)
ADVIP 2018 Work Conference Findings	
Extremely or very useful	54.7(134)
Moderately useful	29.8(73)
Slightly useful	12.65(31)
Not at all useful	2.86(7)

Table 6. Working with researchers

	Percent (*n*)
Satisfaction with working with a researcher	
Extremely satisfied	29.84(74)
Somewhat satisfied	37.9(94)
Neither satisfied nor dissatisfied	27.82(69)
Somewhat dissatisfied	4.03(10)
Extremely dissatisfied	0.4(1)
Expressed likelihood to work with DV researcher	
Extremely likely	41.55(122)
Somewhat likely	32.99(97)
Neither likely nor unlikely	18.37(54)
Somewhat unlikely	5.1(15)
Extremely unlikely	2.04(6)
First choice suggested areas for DV research:	
Prevention	21.53(59)
Rates of physical PV	13.14(36)
Effective treatment strategies	12.77(35)
Abuse dynamics	7.3(20)
Context of abuse	7.3(20)
Rates of non-physical PV	6.2(17)
Impact of domestic violence on children	5.84(16)
Assessment	5.47(16)
DV among ethnic/religious minorities	4.74(13)
DV causes and risk factors	4.38(12)
Impact of DV on victims	2.92(8)
Group treatment	2.92(8)
DV among LGBTQ populations	2.19(6)
Couples and family treatment	1.09(3)